DPHHS-AMDD-135B
(Rev 2/14)

STATE OF MONTANA
Department of Public Health and Human Services

HOME AND COMMUNITY BASED SERVICES
PLAN OF CARE SHORT FORM

Admission Date: _____ (Date)

Annual Update: _____ (Date)

Level I: _____ (Date)

Level II: No _____ Yes _____ MR ☐ MI ☐

Date:_____

Individual's Name (Last, First, Middle)	Address				Phone
Medicaid Number (SSN)	Date of Birth	Height	Weight	Sex	Marital Status
Responsible Party (Name/Relationship)	Address				Phone
Attending Health Care Professional	Address				Phone
Residential Status Veteran ☐ Yes ☐ No	Eligibility Category: ( ) Elderly ( ) Disabled ( ) SDMI		Care Category: *Not applicable for SDMI Waiver* ( ) Nursing Facility (CC1/CC2) ( ) Hospital (CC3)		
Date of Referral	Referral Source		Phone Number		Interview Date

Brief Description of Need for Services

Medical Summary/Allergies/Diagnosis/ICD9 Code

Person-Centered Plan

Discharge Date:

I have a free choice of all qualified providers of HCBS for each service included in my Plan of Care. ☐

I understand there is a Plan of Care cost limit and a limit on the type of services available through the HCBS program. ☐

I have participated in the development of this Plan of Care and agree with it. ☐

Individual: _____ (Signature) (Date) Legal Representative: _____ (Signature) (Date)

Significant Other: _____ (Signature) (Date) CMT Staff: _____ (Signature) (Date)

Health Care Professional:_____ (Signature) (Date)